STATE WIDE

New York StateWide Senior Action Council, Inc.

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Toll-Free Patient's Rights Helpline **1-800-333-4374**

June 3, 2014

To: House Ways and Means Committee
Subcommittee on Health
Hearing: "Current Hospital Issues in the Medicare Program"

Please accept this written statement by Maria Alvarez, Executive Director, New York StateWide Senior Action Council, for consideration by the Committee and for inclusion in the printed record of the May 20, 2014 hearing: Current Hospital Issues in the Medicare Program.

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Title of Hearing: Current Hospital Issues in the Medicare Program

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Statement by Maria Alvarez, Executive Director
New York StateWide Senior Action Council, Inc.
To the House Ways and Means Committee
For consideration and inclusion in the printed record for
Hearing: Current Hospital Issues in the Medicare Program.
June 3, 2014

The New York StateWide Senior Action Council, Inc. is a 41 year-old organization that works toward improving the quality of life of senior citizens and families in New York State.

Through our Medicare Consumer Counseling Assistance Project and Patient's Rights Helpline, we assist thousands of clients annually to make the best informed decisions regarding their healthcare and Medicare health insurance coverage**.**

We have been receiving calls on our Patient's Rights Helpline from distressed seniors with tens of thousands of dollars worth of hospital bills that they had assumed would be paid by Medicare. Application of Observations Status related rules have created financial chaos for many seniors who – no matter what their economic status – are often one nursing home admission short of impoverishment.

We believe that the massive increase in the placement of Medicare beneficiaries into observation status over the last few years has more to do with federal efforts to shift more of the costs of care to older persons and for hospitals' need to protect themselves against penalties for high readmission rates than with any reasons related to clear clinical need or quality of care.

Since its enactment in 1965, Medicare Part A has covered the costs of stays in a hospital and rehabilitation care thus enabling sick older persons to obtain critical care without fear of financial hardship. This core purpose needs to be clearly reaffirmed and maintained.

The rules related to Observation Status need to be fixed to benefit Medicare beneficiaries. Right now attempts to address the problem are piecemeal and ineffective. Individual states are offering possible fixes. CMS has proposed and finalized rules to attempt a partial fix in requiring that beneficiaries in a hospital bed for more than 48 hours need to be admitted. However, the legislative changes are still needed to assure that stays overnight in a hospital count toward the three night minimum for Part A to cover rehab care in a Skilled Nursing Facility (SNF).

We agree with the testimony given by Toby S. Edelman, Senior Policy Attorney at the Center for Medicare Advocacy presented to the House Ways and Means Committee Hearing on May 20, 2014. There has been

a rapid growth in the use of Observation Status (OS), uncertainty regarding the appropriateness of its use, and its potential financial impact on Medicare beneficiaries. Congress must act speedily to rectify the conundrum of observation status and its impact on the ability of Medicare beneficiaries to receive necessary SNF care.

We offer the following recommendations:

- **Establish easier and speedier access to the Observation Status appeals' process for Medicare beneficiaries.**

  The current OS appeals process is a fragmented, labor intensive, time-consuming pursuit for Medicare beneficiaries.

  In New York State, the federally designated Quality Improvement Organization, IPRO, only addresses quality of care and inappropriate discharge issues. Under the current system they do not directly handle OS issues and no effective access to appeal exists. OS problems are left unresolved at the beginning levels of the Medicare Appeals Process. IPRO should be charged with accepting OS appeals in order to make OS appeal decisions enforceable at the very beginning of the Appeals Process. *The Medicare Appeals Processes should be consistent and enforceable at all levels of Appeal.*

- ***To that end, a sick beneficiary and caregiver should not have to deal with OS issues on their own. Community based organizations should receive funding to provide education and assistance to Medicare beneficiaries regarding all aspects of Observation Status***

CMS should authorize their Quality Improvement Organizations (QIOs) (in New York State this would be the IPRO), to provide toll free access to appeals in the same way that discharge and quality of care complaints are now handled.

The current system for appealing observation status is extremely burdensome for the sick older person. It appears to be intentional by CMS with the desired outcome being that people will find it too difficult to appeal or give up. Two sample cases we have worked with illustrate this.

- A 93 year old woman received head injuries and broke her pelvis after a fall. She received an inappropriate assessment and treatment, was prematurely discharged and had to be readmitted because of the severity of her injuries. During her five days of care at the hospital she was placed into Observation Status for all but her last day. She was then discharged from the hospital and immediately admitted to a Skilled Nursing Facility (SNF) where she remained for 43 days for rehabilitation of her many problems.
  She was denied Medicare coverage under Part A for this 43 day SNF stay because she had not been an "admitted" hospital inpatient for three days prior to her stay at the SNF. She owed $18,932.55 to the nursing home for her rehabilitation.

Her caregiver contacted us for help. Through the assistance of IPRO she was able have the hospital cited for several quality of care problems. The IPRO noted, "It is unclear why this patient was admitted to observation services when and inpatient admission would have been fully justified due to the multiplicity of medical conditions treated." In addition, they noted that in this case, "Medical decisions overrule standardized and general criteria for admission."

It was clear that the hospital should have admitted her rather than placing her in observation status. In other words they should have billed Part A for her care. However, when the family appealed the denial

of the nursing home coverage charges, the Administrative Law Judge (ALJ) (it took nine months from the time of the incident to obtain a ruling), said that they were ineligible for coverage because they did not meet the three midnight rule and they couldn't rule on improperly billed care. A classic Catch-22. The Law Judge indicated that they could try to get the hospital to resubmit the bills as a Part A claim and then maybe they could request that the appeal be reopened. How is an already stressed patient or caregiver supposed to accomplish such a feat? In this case, the individual and her caregivers gave up and paid the cost of the nursing home care even though Medicare Part A clearly should have covered it. Thus shifting cost to the consumer.

CMS needs to provide such consumers with coordinated assistance so that when one part of CMS finds a quality problem, the other part of CMS helps them get reimbursed rather than finding loopholes to hide from covering such care through Part A.

- An eighty-eight year old decorated veteran of World War Two broke his pelvis as the result of a fall. He spent the next four days in a hospital bed and was eventually transferred via an ambulance to a Skilled Nursing Facility where he needed three weeks of rehabilitative care. He assumed he had been admitted to the hospital since he could not move from his bed; he did not understand that he had been placed into Observation Status; and would later find out that $6,000 for the costs of his SNF care were not covered by Part A.

  He went through a lengthy and time consuming process to appeal the denial of Medicare coverage of his subsequent stay in a SNF. However, the ALJ indicated that while he had been physically in a hospital bed for four days, since he was not "admitted" for three midnights, he was held financially responsible for the full amount he incurred while in the SNF for rehabilitation. At that stage the family through up their hands and gave up appealing further. Once again the system wore down the victim and transferred the cost of care to the consumer. (for further information see: http://www.timesunion.com/local/article/Observation-status-and-a-nasty-surprise-4106789.php)

These cases are not untypical of the current state of affairs that Medicare beneficiaries face when appealing such findings. The appeals process for Observation Status must be made a way to provide checks and balances rather than as a way to wear down consumers, transfer costs, and shirk responsibility for Part A coverage of post hospital rehab care in a SNF.

New York StateWide Senior Action Council also agrees with the policy recommendations set forth in the AARP Public Policy Institute September 2013 report to:

- **Require hospitals to provide notification to Medicare beneficiaries when they are placed under observation during their hospital stay and explain how Observation Status may affect their health insurance coverage and their out-of-pocket costs associated with outpatient care and post-acute SNF coverage.**

  The New York State Chapter 397 Observation Status Law enacted in 2013, requires hospitals to provide oral and written notice within 24 hours to Medicare beneficiaries placed under observation during their hospital stay, and explain how Observation Status may affect the patient's health insurance coverage. We applaud New York State taking this first step forward and recommend that this become a requirement in all of the States.

Written notice of OS status when it first occurs might reduce later beneficiary confusion about whether SNF care will be covered by Medicare. This required notification may spur beneficiaries to ask more questions about OS and seek assistance from local community groups.

- **Eliminate Medicare's 3-day prior stay requirement for Part A SNF coverage.**

  Medicare does not require a prior inpatient stay for coverage of services by other post-acute care providers, such as home health agencies, inpatient rehabilitation facilities, or long-term care hospitals. Medicare requirements should be consistent.

- **As long as the 3-day prior stay requirement remains in place, count all time spent in OS, as well as time as an inpatient, toward time required to qualify for SNF coverage.**

  There are identical bills (H.R. 1179 and S. 569, the Improving Access to Medicare Coverage Act of 2013) passage of which would require that all time spent in the hospital – whether called observation or inpatient – be included in calculating the three-day inpatient qualifying hospital stay.

- **Cap the total beneficiary liability for OS use at the inpatient deductible amount.**

  This proposal would limit the maximum financial burden for OS use to the amount that beneficiaries would incur for inpatient admission

- **Count OS use as an inpatient admission for purposes of the readmission reduction program**.

  This change would strengthen provider incentives to reduce avoidable readmissions and reduce potential gaming by closing a loophole that may encourage the inappropriate use of OS to avoid readmission penalties.

- **Clarify Medicare criteria for OS and inpatient admission**.

  Such clarification could reduce provider confusion and potential misuse of OS that may be associated with nonclinical considerations. As indicated in the results of a study by Dr. Sheedy, et al of observation status patients in the University of Wisconsin Hospital and Clinics that was published in the November edition of JAMA, many patients studied did not meet the guidelines for observation status. Further, that article notes, "It is uncertain what role, if any, observation status for hospitalized patients should have in the era of health care reform."

Thank you for the opportunity to comment on this important issue.

Respectfully submitted,
Maria Alvarez, Executive Director
New York StateWide Senior Action Council, Inc.